

Account Information Update – Health Unit

Please provide an update of your operations and exposures for our file. This information will be used for the next renewal term.

Legal Name of Applicant _____ Policy Number _____

Brokerage Name _____

Is Provincial Workers' Compensation Insurance carried? YES ☐ NO ☐

Information Required		Comments
Total Annual Payroll including Benefits	\$	
Total Annual Operating Budget	\$	
Total number of:		
Board Members		
Employees (FTE*)		
Volunteers		
Professionals - Total number of (FTE*):		
Medical Officers of Health		
Dental Assistants/Hygienists		
Epidemiologists		
Health Inspectors		
Nurses - Public Health		
Nurses - other		
Audiologists		
Speech Pathologists/Therapists		
Dieticians/Nutritionists		
Social Workers		
Other professionals - specify type		

*FTE means Full Time Equivalent

Professionals

*** The following professionals and professional services are excluded under our policy.**

Medical, surgical, dental, x-ray or nursing services or treatment, or the furnishing of food or beverage in connection with such services or treatment. Other service or treatment conducive to health, pharmacists, furnishing or dispensing of drugs or medical/surgical, dental supplies or appliances Handling of deceased bodies. Cosmetic, body piercing, hairdressing, massage, physiotherapy, chiropractic, hearing aid, optical or optometric services. Preparation of maps, plans, opinions, reports, surveys, field orders, change orders, drawings or specifications. Supervisory inspection, architectural, design or engineering services. Professional advice or activities of accountants, advertisers, notaries, paralegals, lawyers, real estate brokers or agents, insurance brokers or travel agents, financial institutions or consultants. Computer programming, consulting, advisory or related services, Claims investigation, adjusting, appraisal, survey or audit services.

Describe any changes or anticipated changes in your operation or exposures

The undersigned authorized signatory of the organization declares that, to the best of his/her knowledge, the statements set forth herein are true.

Note: At any time if circumstances change in that they may materially alter the risk or exposure, please contact your underwriter with complete details.

Applicant Name _____ Title/Position _____

Applicant Signature _____ Date _____

Broker Name _____

Broker Signature _____